

A better future for the NHS: a historical perspective from the frontline

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In 54 years on the frontline, mostly at tertiary, but also at both secondary and primary levels, I have experienced the best and the worst of the NHS.¹ The recent much-publicised problems and challenges facing the NHS are not new but can be traced to the early 1990s. At that time, a profound change in NHS structure and culture occurred following the 1990 National Health Service and Community Care Act,² when best Service practice was subordinated to best Business practice. In a nutshell, the NHS became the NHB. This led to fragmentation of healthcare, the rapid expansion of an enormous bureaucracy and frequent strains between frontline staff and management at all levels.

The NHS before and after 1990

In the early and mid-1990s, ward closures, bed shortages, bottlenecks, cancelled operations and lengthening waiting lists were as common as they are now. Who can ever forget the head injured patient who in 1995 was helicoptered from Kent to Leeds, where he died soon after arrival, because there was not a single available intensive care bed in the whole of London and the south of England. This well-publicised example was the tip of an iceberg.^{3,4} The iceberg melted slightly with increased NHS funding after the 1997 General Election, but is as big as ever now in the present financial climate. Not that funding is the only important issue.

On 14 December 1995, Turnberg⁵ wrote

There is widespread concern amongst physicians that increasing pressure to take on ever more work is impeding their ability to practice the high standards of medicine to which they aspire. Uncertainty, frustration and even despondency are beginning to threaten the sense of commitment to the NHS of many physicians. I constantly bring to the attention of the Department of Health and the NHS Executive

the damage that is causing to the quality and standard of care we provide . . .

Why were the quality and standards of care falling in the 1990s? Were there not problems in the NHS before 1990? Yes, there were, but nothing of the order or scale that followed the 1990 Act, and existing services were rarely compromised. In particular, there were problems in Mental Health and Community Care because the closure of Mental Hospitals overwhelmed Community Care.⁶ There is also no doubt that financial inefficiency was an issue throughout the NHS, but it could have been addressed more sensibly than in the 1990 Act, for which it was the primary Government incentive. It has been widely forgotten that the Griffiths Report of 1988,⁷ which led to the 1990 Act, was set up to review the failings in Community Care. Griffiths made many sensible recommendations to improve and coordinate care, including a Minister for Community and Social Care, belatedly and partially implemented only this year! The Government ignored most of Griffiths' recommendations but seized upon his suggestion for greater financial efficiency, including the separation of purchasers from providers and the introduction of market forces, and applied it to the whole of the NHS. At the same time, the Act unwisely further separated services in Mental Health and Community Care from physical health, adding to the relative neglect of psychological and social medicine.⁸

Despite the heroic efforts and wonderful achievements of dedicated frontline staff, as well as further reorganisations of a still fragmented Service, the NHS has never adequately recovered from the 1990 Act. Coordination, collaboration, communication and continuity of care are fundamental to the highest standards of medical practice and care, but all have been undermined and compromised since then.^{9,10} Notwithstanding many centres of excellence,

especially in acute physical care, scandals such as Mid-Staffs¹¹ and others are an extreme form of a more widespread decline in standards which have focused continuing attention on patient safety and staff morale.^{5,12}

In the business world, time is money. In the NHS/NHB, time, which is a greatly valued commodity by patients, also costs money. With increasing knowledge, education, expectations and demands, a resource which is in shortest supply is indeed time.¹³ This has given rise to the understandable impression that so much hasty diagnosis and treatment is lacking in compassion and empathy, with widespread calls for a more 'holistic', 'personalised' or 'patient-centred' approach in the NHS.^{14,15} These values have long been central to the practice of medicine and certainly I was so taught in medical school in the 1950s. These calls may be viewed as an indirect measure of a fall in standards. In the increasingly time- and cash-strapped NHS, much has been squeezed or lost in the art of medicine,¹⁶ leading to so much concern about clinical standards now and over the last 25 years.

Clinical standards and financial efficiency

And so the 1990 Act is an important historical key to understanding and addressing many of the continuing challenges today which have flowed from it, aggravated by the increasing demands of an ageing population with complex needs and ever more costly interventions, in a pressurised NHS in which financial considerations compete with and/or override clinical standards.

Nor can I see that the 1990 Act succeeded in introducing financial efficiency. The amount of money wasted in the present fragmented NHS is phenomenal, for example: (1) the enormous managerial bureaucracy with its high and rapid turnover; (2) the frequent reorganisations, mergers, demergers, quangos, think tanks, systems analysts, consultancies, advisory bodies, inspectors and reports; (3) the lack of staff planning leading to huge agency bills and expeditions abroad to recruit staff; (4) litigation; (5) worst of all, the staggering health costs arising from fragmentation and from the lack of continuity of care. Examples include: (a) much waste of time in unnecessary, misguided or defensive clinical re-evaluation and or reinvestigation, sometimes leading to overdiagnosis and overtreatment,^{17,18} and (b) many unnecessary hospital readmissions due to premature discharges resulting from pressures and bottlenecks in the system, some of whom need never have been admitted in the first place with adequate Community Care; in both examples from an enforced but avoidable decline in professional standards.

I find it difficult to believe that the NHS/NHB is financially more efficient now than it was before 1990. I venture to suggest that the most financially efficient NHS is that associated with the highest quality and standards of care, incorporating: (1) evidence-based care when available, which is often not the case, especially in the field of mental health and social care, but also in physical health; (2) reintegration of physical, psychological and social care in a more local, decentralised service; (3) coordinated continuity of care; (4) readily available good communication with a trusted and accountable designated professional, whether as an individual practitioner or the leader of a multidisciplinary team; all of which is in keeping with what patients actually want.^{19,20} With ever more educated and informed patients in the Internet age, the doctor-patient relationship has evolved from more paternalistic to more shared decision-making,²⁰ but either way a trusted relationship between patient and professional, doctor or otherwise, remains cardinal to the highest standards of medicine.

But here is the dilemma. The present problems and challenges in the NHS were predictable and predicted at the time of the 1990 Act, for example by Hoffenberg,²¹ who commented:

Although I have expressed concern about the intrusion of cost-consciousness into clinical judgments, it cannot be ignored. No society (or country) is capable of providing the best available care to all its people all of the time. Cost-containment is inescapable. This means a debate about priorities and rationing of services.

With the steadily increasing demands on the NHS this debate is ever more urgent but it seems ever more avoided. The word rationing, whether overt or covert, is hardly ever mentioned.²⁰ Funding for the NHS is the responsibility of the Government, within its resources and priorities. Standards of physical, mental and community/social care are the responsibility of professionals of all categories. The professionals together with patients and public can help the Government to set health and care priorities but the professionals should concentrate on clinical service standards within a reintegrated and decentralised service and avoid being drawn into political funding decisions for which they will be blamed, at least in part, when it comes to deficiencies and unavoidable rationing, usually covert, in the system. In a better future for the NHS, both clinical and financial efficiency will be more readily aligned, albeit with some overt rationing, in place of the present combination of lower clinical standards and financial inefficiency.

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